Supreme Court, U.S.
FILED

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No. _____

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1994

BILLIE J. COMER, as personal representative of the Estate of Ryan Comer,

Plaintiff-Petitioner,

vs.

KAISER FOUNDATION HEALTH PLAN, INC., THE PERMANENTE MEDICAL GROUP, INC., KAISER FOUNDATION HOSPITALS, and DOES 1 - 50,

Defendant-Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Should a person who causes the death of another be immune from liability for wrongful death based upon ERISA preemption, especially where the wrongful death action is not brought by an ERISA plan participant or beneficiary, where the action is brought against a defendant who is not an ERISA plan or fiduciary, and where the recovery of plan benefits is not sought?

PARTIES TO THE PROCEEDING

Plaintiff-Petitioner:

BILLIE J. COMER as personal representative of the Estate of Ryan Comer,

Defendant-Respondent:

KAISER FOUNDATION HEALTH PLAN, INC., THE PERMANENTE MEDICAL GROUP, INC., KAISER FOUNDATION HOSPITALS, and DOES 1 - 50.

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BILLIE J. COMER, as personal representative of the Estate of Ryan Comer,

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Petition for a Writ of Certiorari
to the United States Court of Appeals
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PETITION FOR WRIT OF CERTIORARI

REFERENCE TO REPORT OF OPINION

There is no published opinion, official or unofficial, delivered in this case. The judgment and memorandum of the Ninth Circuit Court of Appeals are included in the Appendix at Tab A. The underlying order granting summary judgment and the judgment of the District Court are included in the Appendix at Tab B.

GROUNDS FOR JURISDICTION

The judgment to be reviewed in this action was entered by the Ninth Circuit Court of Appeals on December 23, 1994. (The judgment and memorandum are included in the Appendix at Tab A. The underlying order granting summary judgment and the judgment of the District Court are included in the Appendix at Tab B.)

No order respecting a rehearing or granting an extension of time within which to file the petition for a writ of certiorari has been made.

No reliance on Rule 12.3 is made.

This Honorable Court has jurisdiction to review the judgment by writ of certiorari under 28 U.S.C. section 1254.

The Ninth Circuit Court of Appeals in this action determined that this action arises under 29 U.S.C. section 1001, et seq., the Employee Retirement Income Security Act ("ERISA").

RELEVANT STATUTES

The statutes relevant to this action are 29 U.S.C. section 1001, 29 U.S.C. section 1132, and 29 U.S.C. section 1144. The relevant ERISA statutes are included within the Appendix at Tab C.

STATEMENT OF THE CASE

Ryan Comer, a young teenager, suffered from a rare form of pediatric cancer. Ryan Comer died, because he was deprived of necessary medical treatment, the treatment that would have saved his life. The Ninth Circuit has ruled that

his mother cannot recover damages from the health care provider for the loss of her son. The Ninth Circuit has ruled that her damages must go uncompensated.

The Ninth Circuit's ruling was not based on the examination of the facts in this case. Rather, the Ninth Circuit ruled, as a matter of law, that this action is preempted by the Employee Retirement Income Security Act, 29 U.S.C. section 1001, et seq. That legislation, however, provides no remedy to a parent who loses a child through the failure of a Health Maintenance Organization to provide necessary and covered treatment.

Summary of Facts

This is a wrongful death action brought by, BILLIE COMER, the surviving mother of Ryan Comer. Ryan suffered from a rare form of pediatric cancer and required high-dose chemotherapy, supported by an autologous bone marrow transplant ("HDCT-ABMT") as his only hope for

cure. The HDCT-ABMT treatment showed great promise in the treatment of Ryan's disease, but Ryan was deprived of the treatment, not only because his doctors negligently failed to offer the treatment to him, but also because coverage for the treatment was denied by Respondents, (collectively referred to as "KAISER").

Ryan had health and major medical coverage through KAISER (a Health Maintenance Organization (hereinafter referred to as "HMO")) as a dependent of this mother, BILLIE COMER. BILLIE COMER was an employee of AT&T and, on that basis, she and her son were eligible for coverage through the group medical benefit plan sponsored by AT&T.

This wrongful death action asserts claims not against the AT&T employee benefit plan, but, rather, against KAISER. The action is not for the recovery of benefits under ERISA, but, rather, for the premature loss of Ryan's

life as a proximate result of KAISER's negligent and wrongful delay in providing benefits and treatment.

This action was originally filed in the Superior Court of the State of California, County of Alameda. KAISER removed this action to the United States District Court, Northern District of California, on the grounds that federal question subject matter jurisdiction existed. KAISER then moved the court for Summary Judgment on the grounds that Petitioner's claims are pre-empted by ERISA. The court granted KAISER's motion for summary judgment and dismissed the action. Plaintiff appealed the dismissal to the Ninth Circuit Court of Appeals which affirmed the District Court's dismissal. Appellant now petitions this Court for review of the Ninth Circuit's ruling on the issue of ERISA pre-emption of wrongful death actions.

Review of the decision of the Ninth Circuit Court of Appeals is sought under Supreme Court Rule 10.1 on the

grounds that there are special and important reasons therefor and, specifically under Rule 10.1(a) on the grounds that the Ninth Circuit Court of Appeals has rendered a decision in conflict with other United States Court of Appeals on the same matter and under Rule 10.1(c) on the grounds that the Ninth Circuit Court of Appeals has decided an important question of federal law which has not been, but which should be, settled by this Court.

ARGUMENT

A PERSON WHO CAUSES THE DEATH OF ANOTHER SHOULD NOT BE IMMUNE FROM LIABILITY FOR THE WRONGFUL DEATH BASED UPON ERISA PRE-EMPTION, ESPECIALLY WHERE THE WRONGFUL DEATH ACTION IS NOT BROUGHT BY AN ERISA PLAN PARTICIPANT OR BENEFICIARY, WHERE THE ACTION IS BROUGHT AGAINST A DEFENDANT WHO IS NOT

AN ERISA PLAN OR FIDUCIARY, AND WHERE THE RECOVERY OF PLAN BENEFITS IS NOT SOUGHT.

I. The determination of whether a claim "relate[s] to" an employee welfare benefit plan for purposes of ERISA pre-emption is properly addressed by this Court in establishing the proper parameters to be applied in effectuating the pre-emption provisions and to avoid creating unwarranted immunity by the pre-emption of claims which otherwise have no remedy under ERISA.

It requires a great stretch of logic to conclude that common law claims for wrongful death and negligence "relate to" an ERISA plan or conflict with the remedial scheme of ERISA where, as here, there is no claim by a plan participant or a beneficiary, there is no claim for the recovery of plan benefits, and the claim does not implicate the employee benefit plan. Nevertheless, the Ninth Circuit has

ruled that a party who is neither a "participant" nor a "beneficiary" of an ERISA plan is precluded from asserting a common law action for wrongful death against a health care provider that has wrongfully caused the death of a child.

The breadth ascribed to ERISA's pre-emptive scope by the Ninth Circuit is so wide and encroaching that there is virtually no transaction between an ERISA plan and any ERISA outsider which would escape the grasp of the pre-emption provisions. However, as this Court indicated in its decision in Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825, 833 (1988), this extensive sweep of ERISA pre-emption is inappropriate. "[L]awsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even **torts committed by an ERISA plan** . . . although obviously affecting and involving ERISA plans . . . are not pre-empted by ERISA." Id. [Emphasis added].

Given the factors which have been developed by this Court and the appellate courts in determining the scope and application of the "relates to" language of the pre-emption provisions, it is well within this Court's power and interest to apply those parameters to the wrongful death issue and to properly conclude that a wrongful death action, in the context of the facts presented, affects the plan in a manner "too tenuous, remote or peripheral . . . to warrant a finding that the law 'relates to' the plan." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1983).

For several compelling reasons, the maintenance of a wrongful death action, such as the one sub judice, impacts and relates to the plan in a manner "too tenuous, remote or peripheral" to justify pre-emption. First, the parties to the action are not ERISA principals. Numerous appellate courts have concluded that where the state law cause of action at issue does not involve the principal parties to the ERISA

transaction, pre-emption is not warranted. Memorial Hospital, supra, 904 F.2d 236, 249-50 (5th Cir. 1990); Sommers Drug Stores Co. v. Corrigan Enterprises, Inc., 793 F.2d 1456, 1465 (5th Cir. 1986), cert. denied, 479 U.S. 1034 (1987); Perkins v. Time Insurance Co., 898 F.2d 470, 473-74 (5th Cir. 1990). In Perkins v. Time Insurance Co., 898 F.2d at 473, the court noted that "[a] state law claim which does not affect the relations among the principal ERISA entities (the employer, the plan fiduciaries, the plan, and the beneficiaries) as such, is not preempted by ERISA."

The instant case involves a state law wrongful death claim. The action does not affect the relations among the employer, the plan, or the plan beneficiaries since none of those entities are parties to this action. As noted by the Court in Memorial Hospital:

> In Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.

> [citation omitted], we determined that the most important factor for a court to consider in deciding whether a state law that affects an employee benefit plan 'is too tenuous, remote, or peripheral a manner to be preempted' is whether the state law affects relations among ERISA's named entities. '[C]ourts are more likely to find that a state law relates to a benefit plan if it affects relations among the principal ERISA entities. . .than if it affects relations between one of [the] entities and an outside party, or between two outside parties with only an incidental effect on the plan.'

Memorial Hospital, supra, 904 F.2d at 249.

Because the appellant, in the instant action, is not suing as a plan participant or beneficiary, nor is she suing the plan, the administrator of the plan, or her employer, the

parties are non-ERISA, outsiders, and California's state law permitting wrongful death damages is therefore "too tenuous, remote or peripheral" to support ERISA preemption.

Second, the liability sought to be imposed in this case is not derivative of the ERISA plan and does not "relate to" the ERISA plan as the term is used in the pre-emption provision. KAISER owed its own primary, independent duty of care to the petitioners, separate and apart from its duty under the AT&T plan to actually authorize payment of the benefits. (California Code of Civil Procedure section 377.60; Witkin, Cal.Summary, 9th Ed., Torts, Vol. 6, section 1197 [California's wrongful death statute creates a new cause of action based on heirs' own independent pecuniary injury suffered as the result of the loss of a relative]). KAISER breached that duty of care and caused the death of Ryan Comer. KAISER should properly be subjected to liability for its breach of that duty of care. As this Court held in Mackey

v. Lanier Collection Agency & Service, Inc., 486 U.S. at 833, state-law claims for torts committed by an ERISA plan, although obviously affecting and involving ERISA plans, are not pre-empted by ERISA.

Third, pre-emption is not appropriate because pre-emption would strip the survivors of any remedy by which damages for the wrongdoings of KAISER could be obtained. In Perry v. P*I*E* Nationwide, Inc., 872 F.2d 157 (6th Cir. 1989), the Court determined whether an employees' action to rescind a promised benefit plan was subject to ERISA pre-emption. In its determination that ERISA pre-emption did not apply, the Sixth Circuit examined and followed the analysis set forth in Dependahl v. Falstaff Brewing Corp., 653 F.2d 1208 (8th Cir. 1981), cert. denied, 454 U.S. 968 (1981):

> Dependahl held that **preemption of state common law claims**, such as tortious

> interference, **applies when** (1) Congress has indicated an intent to "occupy the field," and (2) **Congress has provided a remedy for the alleged wrong.** 653 F.2d at 1215. . . . We are disposed . . . toward the reasoning of Dependahl, [citation omitted], that **preemption should apply to a state law claim only if Congress has provided a remedy for the wrong or wrongs asserted."**

Perry, 872 F.2d at 162. [Emphasis added].

This Court can properly address and apply those principles to the pre-emption issue presented by this case and should establish, clearly and unequivocally, that the commission of wrongful death of a person will not be condoned by the improper application of the pre-emption provisions of ERISA which creates a vacuum of remedies.

II. The determination of whether a claim "relate[s] to" an employee welfare benefit plan for purposes of ERISA pre-emption is absolutely arbitrary, and the absence of a bright line rule defining the terms has resulted in the improper creation of unwarranted immunity by the pre-emption of claims that otherwise have no remedy under ERISA.

The position of the Ninth Circuit is clearly arbitrary in its treatment of the negligence and wrongful death claims asserted, particularly, against the KAISER health care providers. The inconsistency of the Ninth Circuit's position is highlighted by an analysis of the law's treatment of the different health care roles that exist in this area. In some instances, there is a physician who acts independently, yet whose treatment may be covered under an insurance policy provided by the employee benefit plan. In others, a physician acts under the direction and control of an HMO,

which, in turn, acts pursuant to a contract with the employee benefit plan to provide benefits and care for the plan members. The failure of either physician to prescribe necessary treatment to a patient undoubtedly results in the same catastrophic damages to the patient. Thus, there is no good reason to distinguish actions for malpractice or wrongful death caused by independent physicians from the same actions brought against an HMO physician.

Nevertheless, the Ninth Circuit has created such a distinction. The Ninth Circuit permits state medical malpractice actions to proceed against the independent physicians, holding such cases not subject to ERISA pre-emption. Mertens v. Kaiser Steel Retirement Plan, 829 F.Supp. 1158, 1162 (N.D.Cal. 1993)(citing Mertens v. Kaiser Steel Retirement Plan, 948 F.2d 607, 614 (9th Cir. 1991)). However, the same court dismisses wrongful death actions against the HMO's physician, on the grounds that the

wrongful death claims "relate to" an employee benefit plan, and, as such, are pre-empted by ERISA. Consequently, the Ninth Circuit has created a distinction where none should exist.

Under the Ninth Circuit's analysis, had the failure to prescribe and provide the treatment necessary to save Ryan Comer's life been under the direction of an independent physician, the resulting wrongful death would certainly have been actionable under California's wrongful death laws. However, because the failure to prescribe and provide the necessary treatment for Ryan Comer was under the direction and control of the HMO's physician, the resulting wrongful death is not actionable and must go uncompensated. The Ninth Circuit has improperly created an unprecedented and unwarranted shield of immunity for those even remotely associated with an employee benefit plan.

III. Permitting pre-emption of a wrongful death action in the context of the facts presented here corrupts the expressed and accepted purposes of ERISA and grants an unwarranted and unintended immunity without advancing the purposes of the pre-emption provisions.

In a recent decision castigating the preemptive sweep of ERISA, justices of the Texas Supreme Court expressed their outrage at the misapplication of ERISA:

> Through peculiar federal judicial interpretation, a statutory addition to workers' rights has been converted into a statutory removal of those rights. The law has been reshaped into a form that achieves the converse of its original purpose. . . . I join with a growing number of Courts and commentators who express the concern that through continued misconstruction, ERISA

> has become "quicksand" that "will continue to expand and preempt everything in its meandering path." Jordan v. Reliable Ins. Co., 694 F.Supp. 822, 835 (N.D.Ala. 1988). For the more than 56 million Americans who are enrolled in group health insurance plans . . . ERISA has become more than mere quicksand; it has become a black hole.

Cathey v. Metropolitan Life Insurance Co., 805 S.W.2d 387, 392 (Tex. 1991).

Although ERISA was intended to protect employees and beneficiaries from the wrongful denial of benefits under an employee benefit plan, several courts have disregarded Congress' intent and have allowed the deprivation of rights where Congress intended an addition.

In order to determine whether a state wrongful death action is pre-empted by ERISA, the intent of Congress is the

primary concern. "The question whether a certain state action is pre-empted by federal law is one of congressional intent. . . . The purpose of Congress is the ultimate touchstone." Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 45 (1987). Congress did not intend to create absolute immunity for insurers and health care providers which cause the wrongful death of another.

As was explained by this Court in its decision in Massachusetts v. Morash, 490 U.S. 107 (1989),

> In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from the accumulated funds. [Citation.] To that end, it has established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the

> employee's expectation of the benefit would be defeated through poor management by the plan administrator.

Morash, 490 U.S. at 115. This Court further explained that Congress's express intention in enacting ERISA was "to promote the interests of employees and their benefit plans, . . . and to protect contractually defined benefits." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).

Although in contrast to ERISA's overall purpose, the pre-emption provisions of ERISA, 29 U.S.C. section 1144, were intended to afford "employers the advantages of a uniform set of regulations governing plan fiduciary responsibilities and governing procedures for processing claims and paying benefits." Memorial Hospital System v. Northbrook Life Insurance Company, 904 F.2d at 245-46, citing Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9-11 (1987).

The circuit courts have struggled in attempting to strike a proper balance between fulfilling ERISA's overall purpose, on the one hand, and protecting the interests served by the pre-emption clause, on the other hand. It is clear that ERISA properly applies to an action for recovery of plan benefits, and, accordingly, the pre-emption provisions are properly utilized to afford uniform regulations for the employers. However, where, as here, the factual scenario deviates from one in which the participant or beneficiary seeks the recovery of benefits from a fiduciary under ERISA, the application of ERISA and its pre-emption provisions becomes more complex and problematic. In this case, the Ninth Circuit has actually destroyed the protection afforded by ERISA, while bending over backwards to uphold ERISA's pre-emption provisions. The result of the Ninth Circuit's ruling confers unjust grant of immunity for those who provide medical coverage and care pursuant to a contract

with an employee benefit plan. Certainly, this grant of immunity, unparalleled in the law, was not intended by Congress when the provisions of ERISA were enacted.

A. Granting the unprecedented immunity of ERISA pre-emption in a wrongful death action subverts and defeats ERISA's overall purposes.

Application of a pre-emption rule as employed by the Ninth Circuit in this action would allow those providing health coverage and treatment under an ERISA plan to escape any and all liability for actions based on claims for wrongful death. Such immunity fosters a situation where the insurer or plan would regularly delay treatment and the payment of benefits, wrongfully deny benefits, and engage in other deleterious tactics in order to minimize its financial obligations. Like the criminal who goes unpunished and, thus, fears no reprisal from the State for any criminal acts, pre-emption of a wrongful death action similarly creates no

disincentive to prevent the insurer or plan from committing tortious, and even fatal, acts. Essentially, the immunity of the pre-emption clause creates a "license to kill" by allowing the tortious acts to go unpunished.

For example, if the only damages recoverable under ERISA are the contractual benefits denied by the plan through its insurer, and even those damages can be avoided by simply waiting until the insured dies, it serves the insurer and plan's interest to contest the rights of the insured and deny treatment, even when the benefits are unambiguously provided under the medical plan. In cases of catastrophic illness, economic benefits inure to those insurers and plan which deny life-saving treatments so that the plan participant will die and relieve the insurer and plan of any further obligation to provide catastrophic benefits.

Thus, pre-emption of wrongful death actions, without another remedy under ERISA, would provide an **incentive** to

an insurer or a plan to wrongfully deny benefits where the benefit sought is a life-saving treatment. Unquestionably, this immunity contravenes ERISA's overall purpose of "protect[ing] contractually defined benefits." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 S.Ct. 948, 955, 103 L.Ed.2d 80 (1989).

B. Refusing to permit pre-emption in a wrongful death action does not defeat the pre-emption clause's purpose in providing uniform regulations for ERISA plans.

Conversely, imposing liability for wrongful death does not undermine Congress' concerns in seeking to establish a regulatory framework for protection of ERISA fiduciaries. Indeed, **the damages to be paid in this action are not to be paid by the plan**. As the instant action asserts claims not against the AT&T employee benefit plan, but, rather, against KAISER entities, the damages are to be assessed only against

the KAISER entities, and not against the AT&T plan. Similarly, assessment of damages against the KAISER entities does not affect the ongoing administration of the AT&T plan, because the liability is based on KAISER's own, independent liability for its own, independent conduct.

As the court in Memorial Hospital, 904 F.2d at 250, noted:

> This conclusion [that the pre-emptive scope of ERISA is neither all-encompassing nor unlimited] follows as a matter of common sense from the fact that ERISA plan members and managers are bound to engage in myriad transactions that Congress never considered when it drafted section 514 [Section 1144]. A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully

> insulated legal world that excludes these plans from regulation of any purely local transaction.

Id.

Thus, the court held that the uniform regulatory purpose of ERISA is not implicated where the recovery under the action at issue in no way expands the rights of the plan participants or beneficiaries to receive benefits under the terms of the plan, or where the claims do not directly affect the relationship among the traditional ERISA entities. Id. at 244.

A wrongful death action cannot, by definition, expand the benefits otherwise owed. Rather, it seeks damages for the death proximately caused by the failure to provide benefits and treatment, damages that were already owed. Because no new regulatory or administrative requirements are imposed by allowing the wrongful death action, imposition of liability for

wrongful death does not subject the insurer or the plan to conflicting laws. Rather, the insurer and the plan are protected from potential liability by doing what they are already required and obligated to do.

CONCLUSION

Under the holding of the Ninth Circuit, ERISA, which was enacted to provide protection for and safeguard the benefits of policyholders, has been turned into a shield of immunity for insurers who wrongfully deny benefits and treatment to its catastrophically ill policyholders. The Ninth Circuit has literally created a license to kill.

Where, as here, the protection of the policyholder's life is overcome by the protection of a "regulatory function," it is clear that ERISA has been warped and skewed far beyond its original intent and purpose. The balance originally achieved by the enactment of ERISA must be restored.

In this age of "managed care" where the decisions of doctors are increasingly being overruled, undermined, and amended by those whose only regard is for the bottom line, these issues must now be addressed by this Court. It is respectfully requested that the petition be granted and this matter be reviewed.

Dated this 17th day of March, 1995.

Respectfully submitted,

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APPENDIX

APPENDIX

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APPENDIX A

APPENDIX A

BILLIE J. COMER, Plaintiff-Appellant, v. KAISER FOUNDATION HEALTH PLAN, INC., PERMANENTE MEDICAL GROUP, INC., KAISER FOUNDATION HOSPITALS, INC., Defendants-Appellees.

No. 93-16054

United States Court of Appeals, Ninth Circuit.

Submitted December 14, 1994

Filed and entered December 23, 1994

APPEAL FROM the United States District Court for the Northern District of California (San Francisco) .

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Northern District of California (San Francisco) and was duly submitted.

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court, that the judgment of the said District Court in this cause be, and hereby is AFFIRMED.

BILLIE J. COMER, Plaintiff-Appellant, v. KAISER FOUNDATION HEALTH PLAN, INC., PERMANENTE MEDICAL GROUP, INC., KAISER FOUNDATION HOSPITALS, INC., Defendants-Appellees.

No. 93-16054

United States Court of Appeals, Ninth Circuit.

Submitted December 14, 1994**

Filed and entered December 23, 1994

APPEAL FROM the United States District Court for the Northern District of California (San Francisco) .

Eugene F. Lynch, District Judge, Presiding

Before: BOOCHEEVER, NORRIS, and HALL, Circuit Judges

MEMORANDUM*

This action arises from the death of Ryan Comer after defendants Kaiser Foundation Health Plan, et al. ("Kaiser") denied him benefits for a cancer treatment. Ryan's mother,

Billie Comer, brought a suit against Kaiser for wrongful death in state court. Kaiser removed the case, and the district court granted summary judgment for Kaiser on the grounds that the action was preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 et seq. Comer appeals. We have jurisdiction pursuant to 28 U.S.C. § 1291. We affirm.

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* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by Ninth Circuit Rule 36-3.

** The panel unanimously finds this case suitable for decision without oral argument. Fed. R. App. P. 34(a) and Ninth Circuit Rule 34-4.

APPENDIX B

APPENDIX B

BILLIE J. COMER, Plaintiff-Appellant, v. KAISER FOUNDATION HEALTH PLAN, INC., PERMANENTE MEDICAL GROUP, INC., KAISER FOUNDATION HOSPITALS, INC., Defendants-Appellees.

No. C92 03755 EFL

United States District Court,

Northern District of California.

Filed and entered May 5, 1993

Eugene F. Lynch, Judge of the U.S. District Court

ORDER GRANTING SUMMARY JUDGMENT

The motion of defendants Kaiser Foundation Health Plan, Inc, The Permanente Medical Group, Inc., and Kaiser Foundation Hospitals for summary judgment came on regularly for hearing before this court on April 30, 1993, Kennedy P. Richardson and Albert Lee appeared on behalf of defendants, and Gary Tysch appeared on behalf of plaintiff

Billie J. Comer.

After considering the moving and opposition papers, arguments of counsel and all other matters presented to the Court, IT IS HEREBY ORDERED THAT:

Defendants' motion for summary judgment in the above entitled-action is GRANTED.

BILLIE J. COMER, Plaintiff-Appellant, v. KAISER FOUNDATION HEALTH PLAN, INC., PERMANENTE MEDICAL GROUP, INC., KAISER FOUNDATION HOSPITALS, INC., Defendants-Appellees.

No. C92 03755 EFL

United States District Court,

Northern District of California.

Filed and entered May 5, 1993

Eugene F. Lynch, Judge of the U.S. District Court

JUDGMENT

Pursuant to and in accordance with this Court's Order granting Summary Judgment in favor of defendants Kaiser Foundation Health Plan, Inc. The Permanente Medical Group, Inc., and Kaiser Foundation Hospitals,

IT IS HEREBY ORDERED AND ADJUDGED that plaintiff Billie J. Comer take nothing, and that the action be dismissed on the merits.

APPENDIX C

APPENDIX C

UNITED STATES CODE ANNOTATED

TITLE 29. LABOR

CHAPTER 18--EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

SUBCHAPTER I--PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE A--GENERAL PROVISIONS

Current through P.L. 103-210, approved 12-20-93

§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and

economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that

disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that is therefore desirable in the interest of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the

equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries.

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to Federal courts.

(c) Protection of interstate commerce, the Federal taxing poser, and beneficiaries by vesting of accrued benefits, setting minimum standards funding, requiring termination insurance.

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

UNITED STATES CODE ANNOTATED

TITLE 29. LABOR

CHAPTER 18--EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

SUBCHAPTER I--PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE B--REGULATORY PROVISIONS

PART 5--ADMINISTRATION AND ENFORCEMENT

Current through P.L. 103-210, approved 12-20-93

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of

this section, or

(B) to recover benefits due to him under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provisions of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025 (c) of this title;

(5) except as otherwise provided in subsection (b) of

this section , by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under subsection (c) (2) or (i) or (1) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169 (a) (2) (A) of this title); or

(8) by the Secretary, or by an employer or other person referred to in section 1021(f) (1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a) (5) of this section with respect to a violation of , or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if--

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if

he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(c) Refusal to supply requested information; failure to comply with notice requirements; penalties

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e) (1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such an administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the

administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 per day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b) (4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024 (a) (4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021 (d) of this title

with respect to any participant or beneficiary or who fails to meet the requirements of section 1021 (e) (2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1000 for each violation by any person of section 1021 (f) (1) of this title. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation. The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this

subsection with enforcement under section 1320b-14 (c) (8) of Title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a) (1) (B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021 (f) (1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1) (B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan--

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of--

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon the Secretary of Labor and Secretary of Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a) (1) (B) of this section which is solely for the purpose of recovering benefits due

such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a pan which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each transaction (as defined in section 4975 (f) (4) of Title 26) for

each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975 (f) (5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e) (1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of

the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of--

(A) any breach of fiduciary responsibility under (or

other violation of) part 4 by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)--

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a) (2) or (a) (5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that--

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan without severe financial hardship unless a waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

29 U.S.C.A. § 1144

UNITED STATES CODE ANNOTATED

TITLE 29. LABOR

CHAPTER 18--EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

SUBCHAPTER I--PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE B--REGULATORY PROVISIONS

PAR Γ 5--ADMINISTRATION AND ENFORCEMENT

Current through P.L. 103-210, approved 12-20-93

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section,

and the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in

section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. ss 393-1 through

393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section--

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in

effectuating the policies of provisions of such Act which are superseded by parts 1 and 4 and the preceding sections of this part.

(6) (A) Notwithstanding any other provision of this section--

(i) in the case of any employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides--

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A) (ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter

apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State, qualified medical child support orders (within the meaning of section 1169(a) (2) (A) of this title), and the provisions of law referred to in section 1169(a) (2) (B) (ii) of this title to the extent enforced by qualified medical child support orders.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 1056(d) (3) (B) (i) of this title).

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action--

(A) with respect to which the State exercises its acquired rights under section 1169(b) (3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistant approved under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

Supreme Court, U.S.
FILED
APR 26 1995
OFFICE OF THE CLERK

No. 94-1573

In The

Supreme Court of the United States

October Term, 1994

BILLIE J. COMER, as Personal Representative of the Estate of Ryan Comer,

Petitioner,

vs.

KAISER FOUNDATION HEALTH PLAN, INC.; THE PERMANENTE MEDICAL GROUP, INC.; KAISER FOUNDATION HOSPITALS, INC. and DOES 1-50,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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COUNTERSTATEMENT OF QUESTION PRESENTED FOR REVIEW

Are state law wrongful death actions which arise from the denial of benefits pursuant to the terms of an ERISA welfare benefit plan preempted by ERISA?

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APPENDIX

Appendix A — Memorandum of the United States Court of Appeals for the Ninth Circuit, Filed December 23, 1994 ..... 1a

Appendix B — Additional Statute Involved 5a

OPINION BELOW

Petitioner failed to attach the complete memorandum ("Order") of the Court of Appeals. A complete copy is attached hereto in Appendix A at pages 1a-4a.

ADDITIONAL STATUTE INVOLVED

Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1) is reproduced hereto in Appendix B at page 5a.

Respondents Kaiser Foundation Health Plan, Inc. ("Health Plan"), The Permanente Medical Group, Inc. ("Medical Group"), and Kaiser Foundation Hospitals (collectively, "Kaiser") respectfully request that this Court deny the Petition For Writ Of Certiorari submitted by petitioner Billie J. Comer because applicable law has settled the issue. Prior decisions in the circuits below have held that ERISA preempts wrongful death claims which arise from the denial of employee welfare plan benefits. The overwhelming circuit authority concludes that such claims are preempted even though they are directed at the parties who render the medical advice that is the basis for the denial of plan benefits.

STATEMENT OF THE CASE

Respondents are compelled herein to correct petitioner's misrepresentations and serious omissions pursuant to this Court's Rule 15.

Petitioner erroneously portrays this case as though the court below extended ERISA preemption to common law wrongful death actions against health providers for medical malpractice. In fact, the purported medical negligence was the medical

judgment that the requested autologous bone marrow transplantation procedure ("ABMT") was experimental and therefore excluded from coverage pursuant to the terms of the Group Medical and Hospital Service Agreement entered into between respondent Health Plan and petitioner's employer, AT&T ("AT&T Service Agreement"). As discussed below, this agreement is an integral part of an employee welfare benefit plan. Respondent Health Plan is explicitly named as an ERISA fiduciary in the AT&T Service Agreement for purposes of claims administration, and the challenged medical advice was given for the purpose of determining the claim for coverage that petitioner made on behalf of her son.

The Court of Appeals, relying on its prior holding in *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir.), *cert. denied*, __U.S. __, 114 S. Ct. 1612 (1994), affirmed the trial court's summary judgment ruling in favor of respondents. The claim was dismissed on the ground that petitioner's claims were preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*

Summary of Facts

Petitioner Billie J. Comer is the mother of decedent Ryan Comer. Ryan was a member of Health Plan, a non-profit health maintenance organization ("HMO"), through petitioner's AT&T employee benefit plan. It is undisputed that Health Plan and AT&T entered into the AT&T Service Agreement under which Health Plan undertook to arrange for health care services and benefits for petitioner and other AT&T employees and their eligible dependents. (AOB at 4:22-24, 8:17-18, and 9:1-5.)[1]

1. "AOB" refers to petitioner's opening brief in the Court of Appeals; "CR" refers to the trial court's Clerk Docket Record; "Compl." refers to petitioner's Complaint; "GN" refers to petitioner's attachment to the Complaint.

Petitioner enrolled Ryan as a dependent member under the AT&T Service Agreement by virtue of petitioner's employment with AT&T. (CR 23, 9:1-5.)

As a health maintenance organization ("HMO"), Health Plan does not provide medical or hospital services. (CR 15, 2:21-28.) Rather, Health Plan contracts with The Permanente Medical Group, Inc., a professional corporation, for the rendition of physician services. *Id.* Health Plan likewise contracts with Kaiser Foundation Hospitals ("Hospitals"), a separate non-profit corporation, which operates the hospitals and other facilities where members receive medical care. *Id.*

Petitioner's complaint alleges two causes of action for wrongful death and general negligence arising from Ryan's death as a result of a rare cancer known as Rhabdomyosarcoma. (AOB at 4:9.) Both causes of action are centered on the allegation that Ryan's death was the proximate result of respondents' "failing to provide promised insurance benefits." (CR 1, Compl. ¶ 7.) The insurance benefits in dispute are alleged to be based on Ryan's "group medical coverage" as a Health Plan member. (CR 1, Compl. Attach. GN-1, p. 6.)

In particular, the Complaint alleges that petitioner requested that respondents cover the cost of a certain ABMT therapy for Ryan which was being offered at two hospitals in the Midwest. (CR 1, Compl. attach. GN-1, p. 6.) Petitioner further alleges that respondents denied the requested coverage "because ABMT was considered experimental treatment." *Id.*

The undisputed record below established that Health Plan denied coverage for the requested ABMT therapy because it came within the AT&T Service Agreement's exclusion for experimental services contained in Section 6-A(6) of the Service Agreement. (CR 15, Exh. 3.) This provision states, in pertinent part:

> **(6) Experimental or Investigational Services.** Any Service that Health Plan, *after consultation with Medical Group,* determines to be experimental or investigational. A Service is experimental or investigational if:
>
> > (a) The Service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the Service is authorized by law for use in testing or other studies on human subjects[.]

[Emphasis added.] (*Id.* at 6-7.) Health Plan's conclusion that the ABMT procedure was experimental was based on the advice of Medical Group's Bone Marrow Transplantation Advisory Board. (CR 16, Exh. 2.)

Petitioner's characterization of the case below as a garden variety medical malpractice case has no basis in the record.[2] The Court of Appeal found that petitioner did not sue Kaiser for medical malpractice, but rather because of Health Plan's denial of plan benefits based on the exclusion for experimental procedures. (Order at p. 3a.)

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2. Petitioner filed a separate state court law suit for wrongful death based on general allegations of medical malpractice that did not allude to the coverage dispute under the AT&T Service Agreement. (Alameda County Superior Court Action Number V-005097-1) This separate malpractice action was dismissed by the state court for lack of prosecution.

REASONS FOR DENYING THE PETITION

I.

THE PETITION DOES NOT SATISFY THE CRITERIA FOR CERTIORARI REVIEW.

Petitioner cannot meet the "special and important reasons" requirements of this Court's Rule 10. There is no justification for certiorari review in light of the true character of petitioner's claims.

Petitioner characterizes the decision below as a ruling of first impression. The court below, however, did not undertake a bold extension of ERISA preemption. Rather, the Court of Appeals' holding fully comports with the well established principles of ERISA preemption. (*See* Part II, below.)

The court below joined an unbroken line of circuit authority from within and outside the Ninth Circuit in holding that wrongful death actions are preempted if they arise from the denial of ERISA plan benefits. (*See* Part III, below.) Petitioner's claim that this Court must intervene to resolve a conflict of authority is false.

Furthermore, petitioner's thesis that the decision below deprives her of remedies for wrongful death is a gross overstatement. ERISA does provide her with limited remedies albeit not the remedies that she seeks. (*See* Part IV, below.) In arguing for the right to recover state law tort damages, petitioner is asking the federal courts to rewrite ERISA's carefully circumscribed remedial scheme. The federal courts cannot undo the remedial plan that Congress chose to adopt. Moreover, this Court has held that Congress' remedial scheme is exclusive.

II.

THE DECISION BELOW FULLY COMPORTS WITH THE WELL SETTLED PRINCIPLES OF ERISA PREEMPTION.

Petitioner contends that the Ninth Circuit's finding of ERISA preemption was erroneous on the grounds (1) that she is not litigating this case as an ERISA plan participant/beneficiary, (2) the action does not implicate an ERISA plan since Kaiser is not an ERISA plan and/or fiduciary and (3) that this is not a claim for plan benefits. Each contention is refuted by the record and the controlling case law.

Petitioner's action does not arise from the breach of state law duties with respect to medical negligence. To the contrary, petitioner's claims were centered on the allegation that respondents erroneously determined that the requested ABMT therapy was subject to the AT&T Service Agreement's exclusion for experimental procedures.

For the reasons set forth below, petitioner's claims are preempted because they are inextricably bound to the terms of the AT&T Service Agreement and because they conflict with ERISA's exclusive remedial scheme.

A. The AT&T Service Agreement Is An Integral Part Of An Employee Welfare Benefit Plan.

Petitioner has conceded that her employer sponsored an employee welfare benefit plan governed by ERISA. (AOB at 8:17-18). The AT&T Service Agreement between Mrs. Comer's employer AT&T, and respondent Health Plan, is a vehicle by which AT&T furnishes health care coverage to its employees and their dependents. Section 3(1) of ERISA, 29 U.S.C. § 1002(1)

explicitly states that an employee welfare benefit plan may be maintained "through the purchase of insurance or otherwise." It is well settled that an agreement between an employer and an HMO whereby the HMO furnishes health care coverage to the employer's employees constitutes an ERISA employee welfare benefit plan. *E.g., Barnett v. Kaiser Foundation Health Plan, Inc.*, 32 F.3d 413, 415 (9th Cir. 1994); *McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192 (10th Cir. 1992); *Anderson v. Blue Cross/Blue Shield of Alabama*, 907 F.2d 1072 (11th Cir. 1990).

The AT&T Service Agreement is therefore an integral part of an employee welfare benefit plan governed by ERISA.

B. ERISA Preempts Petitioner's State Law Claims Because They Relate To The AT&T Employee Welfare Benefit Plan.

1. The "Relate To" Standard of Section 514(a) of ERISA

Section 514(a) of ERISA expressly preempts "any and all state laws insofar as they may now or hereafter *relate to* any employee benefit plan." 29 U.S.C. §1144(a) (emphasis added). This Court has emphasized that ERISA's preemption clause is "conspicuous for its breadth." *FMC Corporation v. Holliday*, 498 U.S. 52, 111 S. Ct. 403, 407 (1990). Moreover, this Court has repeatedly held that the phrase "relate to" must be given a "broad common sense" meaning. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S. Ct. 478 (1990), this Court stated:

> A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to a plan. [citation omitted] Under this "broad common-sense meaning," a state law may "relate to" a benefit plan, and thereby be pre-

> empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect. [citations omitted]

498 U.S. at 139, 111 S.Ct. at 483. The preemptive effect of section 514(a) reaches state common law contract and tort claims as well as claims based on state statutes or regulations. *E.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48, 107 S. Ct. 1549 (1987); 29 U.S.C. § 1144(c)(1). This Court has "repeatedly stated that a law 'relates to' a covered employee welfare benefit plan for purposes of section 514(a) 'if it has a connection with or reference to such a plan.'" *District of Columbia v. Greater Washington Bd. of Trade*, __ U.S. __, __, 113 S. Ct. 580, 583 (1992) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)).

This Court has consistently held that state law claims are preempted if they expressly refer to and depend on the existence of an ERISA plan regardless of whether the claim affects the substantive terms of the plan. Thus, in *Ingersoll-Rand, supra*, an employee alleged that he was discharged because the employer wished to avoid making pension contributions on his behalf. The employee argued that section 514(a) should be limited to state laws which regulate the terms or conditions of ERISA plans. However, the Court held that preemption was required because:

> The [state law] cause of action makes specific reference to, and indeed is premised on, the existence of a pension plan . . . Thus, in order to prevail, a plaintiff must plead, and the court must find, that an ERISA plan exists and the employer had a pension-defeating motive in terminating the employment. Because the court's inquiry must be directed to the plan, this judicially created cause of action "relates to" an ERISA plan.

498 U.S. at 140, 111 S. Ct. at 483.

2. Petitioner's State Law Causes Of Action Relate To And Depend On The AT&T Service Agreement

The courts below found that petitioner's claims "relate to" the AT&T Service Agreement within the meaning of section 514(a) of ERISA because they expressly referred to the AT&T Service Agreement. Petitioner's causes of action proceed from the alleged premise that her son, Ryan, "had group medical coverage through [respondents], as a dependent of his mother." (CR 1, Compl., ¶ 6 and Attach. GN-1, p. 6.) Both causes of action allege that Ryan's death was the proximate result of respondents having denied Ryan "promised insurance benefits" in the form of coverage for the requested ABMT therapy under the group agreement. (CR 1, Compl., ¶ 7 and Attach. GN-1, p. 6.) The Complaint further alleges that this denial of coverage was based on respondents' opinion that the requested ABMT therapy was "experimental" (CR 1, Compl., Attach. GN-1, p. 6) — an obvious reference to the AT&T Service Agreement's express exclusion for experimental medical services.

Because it is indisputable that the group health coverage in question is Ryan's coverage as a dependent member under the AT&T Service Agreement, both causes of action directly and expressly refer to the AT&T Service Agreement and the denial of requested benefits. Therefore, they are preempted under section 514(a) of ERISA.[3]

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3. Petitioner erroneously relies upon *Mackey v. Lanier Collection Agency & Service*, 486 U.S. 825 (1988). In *Mackey*, this Court found that mere collection efforts targeted at plan participants affected the plan in a too tenuous, remote or peripheral manner to warrant a finding that it related to the ERISA plan. *Id.* at 841.

C. In The Alternative, Petitioner's Requested Relief Conflicts With ERISA's Exclusive Remedial Scheme.

Apart from the applicability of section 514(a), state law tort claims relating to the administration of claims under an ERISA plan are preempted on the independent ground that they collide with the exclusive remedies set forth in section 502(a) of ERISA, 29 U.S.C. § 1132(a). *E.g., Pilot Life, supra,* 481 U.S. at 52; *Kanne v. Connecticut General Life Ins. Co.,* 867 F.2d 489, 494 (9th Cir. 1988), *cert. denied,* 492 U.S. 906 (1989). The same impermissible conflict is presented by petitioner's claims herein. As in *Pilot Life* and *Kanne*, petitioner is seeking punitive and other extracontractual damages (CR 1, Compl., ¶ 11) which, if recoverable, would undermine the remedial scheme of section 502(a) which excludes such damages.

D. The Claims Against Respondents Medical Group and Hospitals Inextricably Relate To Health Plan's Administration Of The AT&T Service Agreement And Are Therefore Preempted.

Unlike respondent Health Plan, respondents Medical Group and Hospitals are not named fiduciaries under the AT&T employee welfare benefit plan. All of the asserted claims against them, however, are nonetheless preempted by ERISA because such claims are predicated on the allegation that they joined with respondent Health Plan in wrongfully denying benefits. (CR 1, Compl., Attach. GN-1, p. 6.) *E.g., Custer v. Pan American Life Ins. Co.,* 12 F.3d 410, 418-19 (relying on *Mertens v. Hewitt Assocs.*, __ U.S. __, 113 S.Ct. 2063 (1993)); *Gibson v. Prudential Ins. Co. of America,* 915 F.2d 414 (9th Cir. 1990). Moreover, petitioner is not claiming that Medical Group or Hospitals had any duty to her or Ryan outside of the AT&T Service Agreement.

Preemption under section 514 of ERISA does not turn on

whether a defendant is a party to the plan agreement or an ERISA fiduciary. In *Gibson, supra,* the plaintiff alleged state law claims against a doctor, a professional appointment service, and other defendants who allegedly participated in a scheme to deny the plaintiff coverage under a group disability benefit policy. None of the *Gibson* defendants were parties to the plan or plan fiduciaries. The *Gibson* defendants, like respondents herein, would have had no relationship to the plaintiff except for the plan and the claim for benefits under the plan. Thus, the court ruled that the claims against these parties were preempted because they "related to" the ERISA plan under section 514(a) of ERISA. 915 F.2d at 417. Likewise, the court in *Custer, supra,* concluded that the preemption analysis turns on whether the claims "relate to" an employee benefit plan and not on the defendant's status. *Custer,* 12 F.3d at 419.

The same conclusion must be reached with respect to respondents Medical Group and Hospitals. Both causes of action against these respondents explicitly refer to and depend upon the terms of the AT&T employee welfare benefit plan. Although not parties to the AT&T Service Agreement (GN-1, p. 6, ¶ 1), this joint liability is further demonstrated by the fact that petitioner refers to Medical Group, Hospitals and Health Plan jointly under the common name "KAISER" (GN-1, p. 6, ¶ 1). Therefore, the claims against Medical Group and Hospitals satisfy the "relate to" test of section 514(a) of ERISA and are preempted.

As further discussed in part III below, several circuits have held that state law claims against medical providers based on the providers' decisions affecting a plaintiff's coverage under the ERISA plan are preempted. These decisions reinforce the *Gibson* holding and the conclusion that ERISA preempts the claims against all three respondents herein.

III.

THE DECISION BELOW FOLLOWS THE UNIFORM BODY OF CIRCUIT DECISIONS WHICH HOLD THAT ERISA PREEMPTS WRONGFUL DEATH CLAIMS ARISING FROM THE WRONGFUL DENIAL OF HEALTH CARE COVERAGE.

Petitioner attempts to mislead this Court into believing that the ruling below generally extends ERISA preemption to all wrongful death actions. She characterizes Kaiser's coverage determination as run-of-the mill medical negligence in an attempt to argue that the court below erroneously expanded the scope of ERISA preemption.

A. State Law Wrongful Death Claims Are Not Exempt From ERISA Preemption.

Prior attempts to foist extra contractual tort liability on an ERISA coverage claim have failed. In *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 454 U.S. 968 (1992), defendant United Healthcare denied coverage for Mrs. Corcoran's in-patient hospital stay. In the course of denying plan benefits, United HealthCare performed a type of cost-containment service known as utilization review for the ERISA plan. Mrs. Corcoran was a pregnant woman who was denied an in-patient hospital stay. She was sent home and the fetus subsequently went into distress and died.

The *Corcoran* plaintiffs brought a wrongful death action under state law alleging that the unborn child died as a result of negligence. The Fifth Circuit affirmed the lower court's holding which

> . . . found that the state law claim advanced by

> the Corcorans "related to" the employee welfare benefit plan (citing the statutory preemption clause, ERISA §514(a)), and therefore was pre-empted, because "*[b]ut for the ERISA plan,* the defendants would have played no role in Mrs. Corcoran's pregnancy; the sole reason the defendants had anything to do with her pregnancy is because the terms of the ERISA plan directed Mrs. Corcoran to the defendants . . . for approval of coverage of the medical care she initially sought."

Id. at 1325 (Emphasis added).

The *Corcoran* facts are strikingly similar to those alleged by petitioner. For example, Ryan Comer was directed to respondents by the terms of the AT&T employee benefit plan. Moreover, respondents and the *Corcoran* defendants gave medical advice but they did so for the purpose of determining whether the requested procedure was a covered benefit.[4] *Id.* at 1331-1334. This indisputable fact is all that is required to bring petitioner's wrongful death claim within the broad reach of ERISA preemption.[5]

More recently, the Sixth Circuit also held that ERISA preempted a wrongful death claim arising from the wrongful denial of health care coverage. *Tolton v. American Biodyne, Inc.,*

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4. In affirming the lower court's summary judgment ruling, the Fifth Circuit found that although plaintiffs' claims did not explicitly refer to or were premised on an ERISA plan, the negligence-based causes of action had a sufficient relation to the ERISA plan to warrant preemption. *Id.* at 1334.

5. Petitioner's counsel conceded during the summary judgment hearing that there was not much of a difference between *Corcoran* and this case. (CR 23, 10:13-14.)

48 F.3d 937, 1995 U.S. App. LEXIS 4083 (6th Cir. March 3, 1995). The *Tolton* plaintiffs brought a wrongful death action which alleged medical malpractice and other causes of action against the health plan, the hospital as well as the doctors.

As in *Corcoran*, the *Tolton* decedent was denied health care coverage pursuant to a medical care utilization review. He later committed suicide. In ruling that the claims for medical malpractice and wrongful death were preempted by ERISA, the Sixth Circuit held that the claims arose from defendants' refusal to authorize psychiatric benefits pursuant to the terms of the plan. *Tolton*, 1995 U.S. App. LEXIS 4083 at 11. Therefore, the Sixth Circuit ruled that the wrongful death and other state law claims were well within ERISA's preemptive reach. *Id.*

The Eighth Circuit reached the same conclusion. *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993), *cert. denied*, __ U.S. __, 114 S. Ct. 694 (1994). There, the plaintiffs brought a medical malpractice action against the ERISA plan's HMO. The Court of Appeals ruled that the plaintiffs' state law claims for medical malpractice were preempted because they arose from the administration of benefits under the employee benefit plan. *Kuhl*, 999 F.2d at 302-303. Although the *Kuhl* family did not file a wrongful death action, they challenged the defendant HMO's medical advice to deny coverage. The HMO advised against covering Mr. Kuhl's proposed heart surgery and therefore it was then canceled. After further consultation and delays, the HMO eventually authorized the surgery. However, Mr. Kuhl's condition deteriorated. His only alternative was to wait for a heart transplant. Mr. Kuhl died while waiting for a suitable organ.

In affirming the District Court's summary judgment ruling, the Eighth Circuit ruled that the medical malpractice claims were preempted because they arose from the HMO's administration of

ERISA plan benefits and not medical malpractice. *Id.* The *Kuhl* plaintiffs, like Mrs. Comer, suggested that the alleged misconduct went beyond the mere administration of plan benefits. *Id.* However, the Court of Appeals agreed with the trial court's determination that characterizing the HMO defendant's actions as malpractice does not change the fact that the claims were based on the improper administration of a claim for plan benefits. *Id.* at 303.

The Tenth Circuit, in *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505 (10th Cir. 1991), has likewise ruled that state law wrongful death claims relating to the denial of coverage for ERISA plan benefits are preempted. The *Settles* defendant terminated Mr. Settles' health insurance coverage effective October 7, 1986. Subsequently on October 24, 1986, Mr. Settles suffered a heart attack and died five days later. Mr. Settles' widow brought a wrongful death action, alleging that Mr. Settles died as a direct consequence of the termination of insurance coverage. *Id.* at 509. The Tenth Circuit concluded that the allegations related to the employee benefit plan and accordingly ruled that the wrongful death claim was preempted.

Another Ninth Circuit panel had addressed a very similar wrongful death claim in *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, (9th Cir.), *cert. denied*, __ U.S. __, 114 S.Ct. 1612 (1994). Like petitioner herein, Mrs. Spain and other heirs sued under California's wrongful death statute and asserted allegations that directly related to the administration of an employee welfare benefit plan. The *Spain* plaintiffs did not sue for benefits under the plan, but sought damages flowing from the allegation that the insurer negligently denied ABMT coverage. The *Spain* court found that the cause of action for wrongful death was preempted because it was inextricably connected with the administration of ERISA plan benefits. *Id.* at 131.

As in *Corcoran, Settles, Tolton and Spain,* petitioner's claims herein are intertwined with and dependent on the coverage provisions of the AT&T Service Agreement and respondents' denial of benefits based on those provisions. Absent Ryan Comer's alleged entitlement to coverage for the requested ABMT therapy, the liabilities alleged in the present case would not exist. Petitioner's state law wrongful death claims are therefore preempted.

IV.

IN ARGUING THAT ERISA'S REMEDIES ARE INADEQUATE, PETITIONER IS QUARRELING WITH A CONGRESSIONAL JUDGMENT THAT THE FEDERAL COURTS CANNOT OVERRULE.

Petitioner's thesis that respondents have a "license to kill" with impunity is rhetorical hype. Congress has provided petitioner with remedies, albeit not the state tort remedies she prefers.

A. This Court Has Clearly Ruled That Congress Intended to Provide Limited Remedies.

Contrary to petitioner's thesis, the absence of wrongful death damages do not corrupt the purpose of ERISA.[6] ERISA's remedial scheme does not allow for any extracontractual damages including wrongful death damages. The fact that Congress failed to provide for these damages leads to the

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6. Both Mrs. Comer and the *Tolton* plaintiff mistakenly rely on *Perry v. PIE Nationwide Inc.*, 872 F.2d 157 (6th Cir. 1989), *cert. denied*, 439 U.S. 1093 (1990), for the proposition that ERISA does not preempt state law if ERISA does not provide a remedy for the alleged wrong. In fact, *Perry* reaffirmed this Court's conclusion that ERISA's remedies are exclusive. *Perry*, 872 F.2d at 161.

conclusion that Congress specifically intended to limit relief to certain delineated remedies. Moreover, Congress' remedial scheme would be completely undermined if claimants were able to obtain remedies under state law that Congress rejected in ERISA. *Pilot Life,* 481 U.S. at 54. Indeed, this Court has explicitly stated, "[t]he six carefully integrated civil enforcement provisions found in §502(a) of the statute . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." *Mass. Mutual Life Ins. Co. v. Russell,* 473 U.S. 134, 146 (1985). The ERISA wrongful death precedents discussed above have simply followed this Court's determination that Congress intended ERISA's civil enforcement scheme to be exclusive.

B. Contrary to Petitioner's Assertions, ERISA Does Afford Her Remedies For The Alleged Wrong Although Not The Extracontractual Remedies That She Seeks.

ERISA does provide petitioner and similarly situated plaintiffs with a remedy. Petitioner, as in other cases involving contested experimental procedures, could have sought a declaratory judgment and a preliminary injunction while Ryan was still alive, which, if granted, allows the patient to undergo the disputed procedure at the insurer or benefit plan's expense. *E.g., Tolton,* 1995 U.S. App. LEXIS 4083 at 16, n. 4; *Pirozzi v. Blue Cross-Blue Shield of Virginia,* 741 F. Supp. 586 (E.D. Va. 1990). Alternatively, petitioner could have brought an action for reimbursement for the cost of the disputed experimental procedure under section 502(a) of ERISA. *Tolton,* 1995 U.S. App. LEXIS 4083 at 16, n. 4. If she prevailed under either claim she would also recover her attorneys' fees. 29 U.S.C. § 1132 (g).

Although the issue is not germane to ERISA's preemption of petitioner's claims, petitioner clearly had standing to sue for the aforementioned remedies under section 502(a) because she

herself was a participant under the AT&T plan. *Id.* Petitioner is therefore in the same posture as the plaintiff in *Pilot Life, supra,* in that she could have pursued claims under ERISA's exclusive remedial scheme. Under section 502, her remedies included "Relief [in] the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits." *Pilot Life,* 481 U.S. at 53. Petitioner's preference for state tort damages as a remedy for this alleged wrong is beside the point since ERISA preemption is determined on the basis of the nexus between the alleged wrongful conduct and the ERISA plan.

Petitioner contends that she only seeks tort damages from respondents and that her action will have no financial impact on the AT&T plan. The lower courts have readily rejected such naivete, recognizing that the cost of extra contractual tort liability would ultimately be borne by the employers who sponsor ERISA welfare plans. *E.g., Holmes v. Pacific Mutual Life Insurance Co.,* 706 F. Supp. 733, 736 (C.D. Cal. 1989).

Despite petitioner's disagreement with Congress' judgment, the fact remains that Congress made a carefully considered decision to devise a comprehensive, albeit limited set of statutory remedies for the wrongful denial of ERISA plan benefits. In sum, ERISA preemption does not turn on whether ERISA affords a complete remedy for the alleged wrong. If it did, then the line of cases including this Court's opinion in *Massachusetts Mutual Life Ins., supra,* which confirm the unavailability of extracontractual damages under ERISA, must also be overruled. Indeed, if petitioner's claims are not preempted, the exclusive, uniform remedy intended by Congress would be undermined by lawsuits brought by the spouses and children of *living* plan participants for loss of consortium as well as lawsuits for the alleged wrongful death of deceased participants.

CONCLUSION

On the basis of the foregoing, respondents respectfully ask that the Court deny the petition for certiorari.

Respectfully submitted,

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APPENDIX A

MEMORANDUM OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT, FILED DECEMBER 23, 1994

NOT FOR PUBLICATION
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 93-16054

D.C. No. CV-92-03755-EFL

MEMORANDUM*

BILLIE J. COMER,

Plaintiff-Appellant,

v.

KAISER FOUNDATION HEALTH PLAN, INC. PERMANENTE MEDICAL GROUP, INC.; KAISER FOUNDATION HOSPITALS, INC.,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of California
Eugene F. Lynch, District Judge, Presiding
Submitted December 14, 1994**
San Francisco, California

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* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by Ninth Circuit Rule 36-3.

** The panel unanimously finds this case suitable for decision without oral argument. Fed. R. App. P. 34(a) and Ninth Circuit Rule 34-4.

Appendix A

Before: BOOCHEVER, NORRIS, and HALL, Circuit Judges

This action arises from the death of Ryan Comer after defendants Kaiser Foundation Health Plan, et al. ("Kaiser") denied him benefits coverage for a cancer treatment. Ryan's mother, Billie Comer, brought a suit against Kaiser for wrongful death in state court. Kaiser removed the case, and the district court granted summary judgment for Kaiser on the grounds that the action was preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 et seq. Comer appeals. We have jurisdiction pursuant to 28 U.S.C. § 1291. We affirm.

Ryan Comer had health and major medical coverage as a dependent of his mother, plaintiff Billie Comer, who was an employee of AT&T and a member of AT&T's group medical plan. AT&T and Kaiser entered into the Group Medical and Hospital Service Agreement, which provided that Kaiser would render physician and other medical services to AT&T group medical plan members, including Billie Comer and her son, Ryan.

Ryan was diagnosed with a rare form of pediatric cancer. His mother requested that Kaiser administer a particular treatment for that cancer, high dose chemotherapy with an autologous bone marrow transplant. Kaiser denied coverage for the treatment on the grounds that it was "experimental" and, as such, was not covered under the terms of the Group Medical and Hospital Service Agreement which explicitly excluded coverage for experimental treatments. Subsequently, Ryan died.

Comer brought this wrongful death suit against Kaiser, alleging that Kaiser's denial of benefits coverage for the cancer treatment proximately caused her son's death. This appeal raises

the question of whether ERISA preempts a wrongful death suit against a Health Maintenance Organization for its refusal to approve benefits pursuant to a service agreement arranged with an employer.

ERISA broadly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In general, state law tort actions relating to the administration of claims under ERISA are preempted. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987). Comer argues, however, that the action does not arise under ERISA and is not preempted by its requirements. Comer argues that she is not bringing this action as a plan participant or beneficiary, and does not claim plan benefits. She points out that AT&T is not a defendant, and argues that the action, therefore, does not implicate the ERISA plan established by AT&T.

We disagree. Comer did not sue Kaiser for medical malpractice. Rather, Comer sued Kaiser precisely because Kaiser determined that her son was not entitled to coverage for the cancer treatment under the Group Medical and Hospital Service Agreement. This service agreement is an integral part of AT&T's group medical plan. As such, an action challenging a decision pursuant to that agreement "relate[s] to an[] employee benefit plan" and is preempted. 29 U.S.C. § 1144(a).

We hold that *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993), *cert. denied*, 114 S. Ct. 1612 (1994), is controlling authority in this case.[1] In *Spain*, we held that a state cause of

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1. Comer's attempt to distinguish *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993), *cert. denied*, 114 S. Ct. 1612 (1994), is unavailing. Supp. Letter Br. at 1-2. Comer's real argument is with *Spain*, *see id.*, which this panel is not at liberty to overrule.

action for wrongful death seeking damages for a plan administrator's alleged improper withdrawal of coverage for a cancer treatment was preempted by ERISA. 11 F.3d at 131-32. This similar action for wrongful death seeking damages for a Health Maintenance Organization's refusal to approve coverage pursuant to a service agreement is therefore preempted as well. That ERISA does not ordinarily authorize suits for compensatory or punitive damages, *Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063, 2068 (1993), does not affect our preemption analysis. *Spain,* 11 F.3d at 132.

Comer alternately argues that remedies for wrongful death damages must be engrafted onto ERISA in "a body of ERISA common law" in order to effectuate congressional intent. Bl. Br. at 18. We have declined to create federal common law causes of action which are inconsistent with the exclusive remedies established by ERISA. *See, e.g., Kim v. Fujikawa,* 871 F.2d 1427, 1432 (9th Cir. 1989) (refusing to engraft a cause of action for contribution onto ERISA). While federal common law can be created to fill a void which Congress forgot to address, *e.g., Kunin v. Benefit Trust Life Ins. Co.,* 910 F.2d 534, 539 (9th Cir.), *cert. denied,* 498 U.S. 1013 (1990), no such void exists with respect to relief under ERISA. ERISA authorizes suits by beneficiaries against fiduciaries for "appropriate equitable relief" only, 29 U.S.C. § 1132(a)(3)(B), and we decline to read alternate remedies into this explicit provision.

AFFIRMED.

APPENDIX B

ADDITIONAL STATUTE INVOLVED

Section 3(1) of the Employee Retirement Income Security Act, 29 U.S.C. § 1002(1).

SUBTITLE A - GENERAL PROVISIONS

DEFINITIONS

Sec. 3. For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions).